CALIFORNIA
AND
WESTERN MEDICINE

VOLUME XXXII MAY, 1930 No. 5

PROBLEMS CONFRONTING THE MEDICAL PROFESSION

PRESIDENTIAL ADDRESS, CALIFORNIA MEDICAL ASSOCIATION, FIFTY-NINTH ANNUAL SESSION

By MORTON R. GIBBONS, M. D.
San Francisco

LAST year, by way of introducing the subject which I expected to discuss in the following remarks, I recounted some of the problems which the old records show to have been the problems confronting the medical profession of California seventy-five years ago. My rudimentary forecast made at that time of the scope of my present subject shows that I displayed little conception of the problems which more thought has revealed.

Whereas the problems of the pioneers arose mainly from within, ours come mainly from without. Comparatively, medical practice then was a fixed matter—ours is in the midst of important changes, just as are all phases of social and business activity.

Our problems are mainly from without in the sense that the ways of the world today bear upon us so heavily that either we must present a firm front if we wish to preserve long-established medical custom, or succumb to pressure from various directions and alter our concepts of what is proper. What shall we do? What shall we change? Shall we make the first move? Shall we wait until the pressure can no longer be resisted and be overwhelmed? Or shall we study our problems, prepare ourselves and act when it seems expedient, and approach our destiny in a manner of our own selection by virtue of special knowledge and preparedness. I fancy the last is our *best* course.

I have selected two important topics which seem to me to deserve your thought. One is the influence which the physician wields in society, and the other is the tendency toward some form of state health care. These matters may not appear to be related, but I can see a very positive dependence of one upon the other.

INFLUENCE OF THE PHYSICIAN IN SOCIETY

The esteem in which we are held as a group has everything to do with proper direction of the changes which many of us think are inevitable.

The medical profession is the largest educated group with a common interest. It is a highly educated group. It has a very high proportion of good minds; yet, are we respected and do we carry weight in proportion to our mental equipment and attainments? I think not. If not, what are the reasons? I believe that it is because (1) we are not a business group; (2) we submit to exploitation; (3) we do not exhibit cohesion or concert of action; (4) we do not talk the same language as laymen; (5) our code of ethics disconcerts them.

(1) *We are not a business group*—that is, we are not businesslike. The income and aggregate wealth of physicians is not comparable to that of others outside of our profession bearing comparable responsibilities. Power and wealth are so nearly synonymous in this country that, not having wealth, we have no power. To the layman the money value of a physician counts as much as does that of another layman. The same attitude is true to marked extent even among ourselves. Yet we well know that a physician's income is not determined by his scientific value. What I am working up to here is a statement of my positive belief—that the California Medical Association does well to have a substantial (impressive would be better) reserve fund, if for no other purpose than for the world to contemplate.

(2) *We submit to exploitation.* Does it ever occur to you that it is illogical for the medical profession to take care of the sick poor for nothing? It is the habit of laymen to assert that we have our compensation in our experience. Not one-fifth of the work which a physician does for the poor is of any value to him, unless it is that it occupies his time, and diverts his mind from unhappy contemplation of his spare time.

The physician is not responsible for his fellow man's poverty. But society is. If society permits the poor man to exist, then society should share equally with the physician the burden of the poor man's sickness. I don't know what we can do about it. I don't know that we should do anything different if we could. Probably it is best to do as we do, and retain the consciousness of doing the decent thing.

Have you ever realized how we are exploited, and why? Most philanthropic work requires services of physicians prominently in its structure. The machinery is set up and the physician is more or less pleased to act as an essential part for

nothing or for a fee far smaller than that which other officials of equal importance would accept. Is he ever offered compensation commensurate with his importance in the humanitarian scheme? He is not. The philanthropist gets the glory because he gets the publicity. The physician gets none; he has no publicity. His satisfaction is found in the opportunity for service. But the public never understands that sort of thrill!

(3) *We do not exhibit cohesion or concert of action.* We do not organize strongly. Comparatively few individuals will put themselves out for the good of the group.

Any Rotary Club can get more done than any medical group and in a minute fraction of the time. The reason is Rotary is a unit. A member must pull his own weight, must work and must attend meetings, or else get out and make room for someone who will. Rotary publicity is faultless. Whatever individuals may be or do, Rotary principles receive the publicity, and the principles are easily understood and above reproach. Did you ever hear of an individual Rotarian making comment or expressing opinions on Rotary business for public consumption? No.

Unhappily, the medical man dearly loves to express minute variations in nonessentials. It is not undignified to say the same thing in the same way as one's confrères or to find out from one's associates what others are doing and thinking. but it is not necessary to engage in quarrels over minor differences of opinion. The newspapers and the public love an internal scrap, but our prestige falls every time it happens.

Why is it that when a man gets in the limelight he is so prone to make statements at variance with the best interests and expressed policies of his confrères? He knows that the newspapers will use his words as they see fit. Sadly enough, he is often willing to talk without knowledge of his subject. He seems to feel that he acquires virtue by his puny exhibition of independence. He makes himself—and the rest of us—ridiculous. The public is delighted when newspapers provoke acrimonious discussions.

(4) *We do not speak the same language as the layman.* The medical specialty is farther removed from the bulk of human activities than are all others, than possibly the clergy. We literally speak a different language. Everyone likes to exercise any thoughts he takes interest in as well as anything in which he has developed facility. It is natural, but thoughtless, for physicians to talk shop among laymen. Medical affairs always imply trouble or disaster to a layman. To a physician the scientific considerations are interesting and technically pleasing.

These attitudes cannot be reconciled. One way to be less misunderstood by the public is to discuss medical subjects with them and make them understand, and not discuss cases with other physicians in the presence of laymen in a manner they cannot understand. Some doctors exhibit shocking bad taste, as well as commit tactical blunders along these lines. We are not understood, but that is no reason why we should actively cause misunderstanding.

Did it ever occur to you that we are suspected of some unfathomed but very clever trick because we do not patent our discoveries, and because we go about apparently trying to forestall perfectly good business by practicing preventive medicine?

It has become the common trait of the American, as the ratio of the knowledge in his possession to the whole store of knowledge diminishes, to exercise his vanity, or save his face, by assuming a cheap cynicism and disbelief. This is directed most toward medical matters. Gullibility remains the same. Hence the conservative claims of the scientist are discarded in favor of the ballyhoo of the charlatan.

But ignorance and misunderstanding are not always spontaneous. There is a calculating kind of hostility and antagonism. There is active mobilization of ignorance and prejudice by agencies actively hostile to medical science.

(5) *Our code of ethics disconcerts the layman.* Our code of ethics is commonly thought to be a provision for our own advantage; whereas it is designed primarily for the protection of all society.

Our ethics and customs are time-honored; and the mechanism has been well worked in and is reliable.

Such prosperity as that of certain of our notorious licentiates is attractive. If one is endowed with the Barnum characteristics, and is not trammeled by ethical considerations, he may prosper to a much greater degree than he who retains the respect of his confrères. Plenty among us have the requisite daring but not the lack of standards.

The fact is we know intuitively, even if we have not reasoned it out, that our present standards of interrelation within the profession are the best for the public and the best for ourselves. Individuals and little groups depart from our standard, attracted away for short adventures, but few fail to gravitate back to the substantial mass. They would be grieved and shocked if they could not have communion with the parent group and find sanctuary in its laws, no matter what they may do to others. They are like the traffic violators who take liberties with the rights of others, but complain most bitterly when their own rights are infringed.

The successful man, high in his profession, who through a subconscious feeling that the laws do not apply to him because of his power or position, would be scandalized if he could not have the protection which he should give to his less fortunate brethren.

The mark of the strong man everywhere is punctilious observance of the rights of others.

It lies in a sense of fair play; and it is exactly that which our ethics mean.

We do not need to depart from, nor ever alter our standards. If we do adhere to the old standards, what then. I am no idealist in the sense that I believe the profession to be chemically pure. I have ample evidence that there is a proportion of the profession, but not nearly so large as in other callings, whose excellence of behavior is in direct ratio to the proximity of the police, so to speak. In that we are just the same as our lay fellow citizens. However, the high-minded and high-principled majority will always remain the same, and there can be no failure of our standards by a process of attrition. No change is necessary in our standards.

Can anyone doubt that the ethics of business and government and all human relations have become higher within our own time? We may be beset, but we will be strong if we will present the unbroken front of our common understanding and our ethical cohesion. We must play our own game with our own rules—not try to play the other fellow's game.

TENDENCY TOWARD STATE HEALTH CARE

And now I come to the most important economic subject before the medical profession today—state health insurance.

All about us are evidences of forces working in that direction: (1) The various federal provisions for wholesale health care, the Army, Navy, Public Health Service, Veterans' Bureau, and all that these embrace. (2) The state and city health machinery. (3) County hospitals providing medical care at wholesale rates. (4) Employers' hospitals and health service. (5) Workmen's compensation for industrial injuries. (6) Private health insurance and hospital associations. (7) And most of all, the attention focused on the high cost of medical care by the activities of the national committee.

It will be easy for the people to accept the idea of state health insurance. Insurance is understood and is gaining more adherents every day, due to the supposed efficiency and economy of large organizations. Hence, it will be easy to reason that the independent doctor is inefficient, whereas the medical machine would be efficient. Such reasoning, we know, is not true without important qualifications, but we must be prepared to convince many people.

If we exhibit prejudice, we can have little influence in shaping legislation.

Chester Rowell, a friend of our profession and a man who has more intimate knowledge of our problems than any other layman of whom I know, would have some European system of health insurance adopted in California. He said what is good enough for Europe is good enough for us.

I cannot believe that he had in mind the inhuman treatment, the long dreary queues, the obliteration of the individual which the European methods entail. No American public would submit to such treatment.

I believe Mr. Rowell spoke of an idealized system of health insurance when he spoke as he did at the Commonwealth Club. And he does not want, I am sure, the manner of treatment of European patients, with its herding and bullying. Nor does he want the application of the methods of our own workmen's compensation law to health insurance. It is customary to consider the California Workmen's Compensation Law to be practically perfect. It is a remarkably effective law and is administered in an enlightened manner. However, in its insurance phase, where the patient-doctor relation comes in, it permits the interposition between the patient and the doctor of a layman, ordinarily without sympathy or knowledge or appreciation of the delicate balance necessary for the best results.

The production of the traumatic neurosis cases is chargeable in a large measure to this arrangement. There is no means of knowing to what degree this is a fact. My estimate is that one-half of all such cases are precipitated or aggravated by unsympathetic or harsh or misguided handling by laymen. These conditions should be prevented.

Another objection to lay intervention is that laymen have shown a knack for selection of doctors who are insurance-minded, or are at least pliable. The doctors reflect the insurance company's attitude toward the injured. The fine example of some insurance companies which have enlightened medical supervision shows what is possible.

As I said above, the Workmen's Compensation Law is a splendid law and I gladly pay tribute to it. It is brought into the discussion to emphasize the fact that a state health insurance law must possess all necessary good features and, besides, qualities which will prevent the possibility of entrance of bad features.

We must become experts and we must be able to prove to the people of California that what we advocate is the best.

Bear in mind that the first attempt at a state health law will probably be made by enthusiasts. The chances are that the desire to pass the law will be far stronger than the desire that it be right.

I have avoided reference to other subjects in an effort to focus attention on the important subject which is here considered.

In times of stress the medical profession has gotten together, but generally it was too late. Let us make it not too late this time.

Let us make of ourselves the best-informed group on health insurance in California.

Let us prepare our minds to join quickly in furtherance of a sound plan when it is presented.

Let us stand ready to throw our weight and resources of knowledge behind that plan.

Let us be ready to mobilize with alacrity.

Above all, let us select leaders whom we can trust—and then trust them.

350 Post Street.

SUPERIOR MESENTERIC THROMBOSIS

REPORT OF CASES

By WILBURN SMITH, M. D.
Los Angeles

DISCUSSION *by John Homer Woolsey, M. D., San Francisco; Thomas O. Burger, M. D., San Diego.*

SUPERIOR mesenteric thrombosis was practically unknown until that brilliant German pathologist, Virchow, discovered and described a postmortem case of a superior mesenteric artery enlarged, and so completely closed with a thrombus that it appeared as a fibrous cord. The patient, a woman, had succumbed to some other disease, and he wrote in detail of the case in 1847. The clinical side is not reported, for the condition had existed for some time, and nature had established a collateral circulation. This type of case usually passes unrecognized and is often entirely overlooked, being diagnosed as one of colic, or some partial intestinal obstruction. The patient may recover and succumb to some other disease. A postmortem may never be made, and should one be made the examiner may not be thorough enough to examine all the tissues, as did the brilliant Virchow, and so the condition never be discovered.

This condition is not common, for since the first careful description in 1847 about five hundred cases have been described, with only thirty-five of these surviving the attack whether operated or not. This gives the appalling mortality of 93 per cent. The artery is involved about five times as often as the vein, and the superior mesenteric is involved about forty times more often than the inferior. It is true the amount of intestine supplied by the superior is much greater, as it extends from the duodenum to the anastomosis with the inferior at the middle colic. Also Litten maintains that the superior is a type of end-artery and has more of a tendency to favor an infarct, while the inferior tends to establish a collateral circulation. One would suppose in an artery which forms arcades that collateral circulation would easily and most frequently obtain. Even though Virchow,[1] Karcher,[2] Chiene,[3] and others have discovered cases in the postmortem room that had died of other more marked pathology, yet collateral formation is the exception in this artery. Karcher's case was in a woman, forty-one years of age, who had cardiac decompensation symptoms with abdominal pain. She developed femoral thrombosis, and in six weeks was operated upon for gangrene of the leg. She died a week later and on postmortem showed, in addition to disease of the mitral, tricuspid and aortic valves, lateral thrombi in both auricles, infarcts in lungs, spleen and kidney, an obliterating thrombus in the profunda femoris and, what is more interesting, a thrombus obliterating completely the superior mesenteric artery for a distance of thirty-seven millimeters. This thrombus was firmly adherent to the walls of the artery, but in spite of the same there was only slight reddening of the mucous membrane of the ileum. Chiene's case showed an aneurysm in a woman sixty-five years of age with the celiac axis, superior and inferior, involved; and the latter vessels were completely obliterated, forming fibrous cords.

The causes of this rather rare condition may be better studied if we separate the pathology of the artery from that of the vein. Under the artery we think first of embolus which is often followed by thrombus, or of thrombus alone. The embolus comes from heart valves and vegetations, from atheromatous plaques, and from the breaking-up of a thrombus in the auricles or ventricles. The thrombus arises from diseased arteries, from aneurysm with extension of the clot, and from pressure on an artery due to an aneurysm or a tumor. In venous involvement various causes which may injure the veins, or infect them, or a combination of the two, are the factors. The more frequent causes are crushing and ligating of the appendicular veins, pelvic surgery where adhesions are present, splenectomy, volvulus, intussusception, strangulated hernia or extension from the splenic or portal veins. Clinically arterial and venous thrombi differ in that the arterial thrombus disposes to be sudden in onset, while the venous tends to be gradual.

EXPERIMENTAL WORK

Much experimental work has been done to ascertain the exact pathology and account for the variety of clinical symptoms manifest in these cases. Sprengel's theory that obliteration of an artery gave an anemic infarct, while the same in a vein gave an hemorrhagic one, does not here obtain; for, regardless of the cause, the infarct disposes to be hemorrhagic. This hemorrhagic infarct is usually followed by peritonitis, the mucous membrane ulcerates and breaks down with hemorrhage into the canal. The mesentery becomes edematous and the intestine may perforate and cause the peritonitis from macroscopic lesions. Extensive gangrene may develop in forty- eight hours and there may or may not be a distinct line of demarcation.

Following Litten's suggestion that the arteries are terminal, various experiments, namely, ligation of the artery or vein; making of artificial emboli by oil which is not typical and so not parallel; cutting portions of the mesentery along the intestinal attachment to study the effect on